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INTEGRATION OF HEALTH EDUCATION IN UNDER GRADUATE MEDICAL CURRICULUM

REPORT OF THE NATIONAL WORKSHOP

(January 17-19, 1979)

Organized by:

CENTRAL HEALTH EDUCATION BUREAU,
DIRECTORATE GENERAL OF HEALTH SERVICES,
KOTLA ROAD,
NEW DELHI - INDIA

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OBJECTIVES OF THE WORKSHOP

The following were the general objectives of the three-day Workshop :

1. To prepare a report proposing modifications to the existing curriculum for undergraduate medical education integrating the practice and theory of health education with the pre-clinical, para-clinical, clinical and intern phases of medical education.

2. To identify the educational functions performed by doctors in relation to (a) patients, their families and the community, (b) as supervisor of the health team, and (c) as adviser to authorities in relation to health matters.

3. To draft proposals for integrating health education with every aspect of a doctors' clinical and community work.

4. Propose a plan of action for its implementation.

The participants were divided into four working groups. With a view to covering all the medical subjects, each group was assigned the following areas with the following objectives :

1. To consider the general objectives of the Workshop.

2. To identify the opportunities for the teaching of health education during every phase of the undergraduate medical curriculum and the basic and advanced skills which the students should learn during each phase.

Group 1 : Medicine, Physiology, Psychiatry, Pharmacology, Microbiology, Toxicology.

Group 2 : Surgery, Anatomy, Radiology, Pathology.

Group 3 : Obstetrics & Gynaecology, Pediatrics, Ophthalmology, ENT.

Group 4 : Community Health.

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GENERAL RECOMMENDATIONS OF THE WORKSHOP

The National Workshop on Integration of Health Education in Medical Curriculum after an indepth study of the subject unanimously recommended that there is an urgent need for making the entire medical faculty aware of its responsibility for implementation of health education of the community through its integration in the undergraduate medical education. The groups felt that it was necessary for the students to develop skills in communication to perform their role as doctors. The participants of the Workshop were divided into four groups and each group provided its recommendations in general aspect of the subject as well as integration of health education in different subjects of the medical curriculum.

The general recommendations of the groups were based on the following two realisations :

1. Individual patients and the community play a major role in promoting health, preventing sickness and recovering from illness.

2. It is the role of the medical faculty to encourage, inform and train the students in the art of establishing relationship with the people they wish to serve.

The specific recommendations as set by the groups were as under :

1. Health education should form an important component of the undergraduate medical curriculum in its totality.

2. All members of the faculty irrespective of their speciality should be involved in the teaching of this subject so that students realise that there in no compartmentalization in the teaching of this subject.

3. Health education of the patients can best be imparted in hospital settings though family settings and community placements should not be ruled out.

4. Students on entering the medical colleges need to be given lectures on medical ethics and various aspects of personal hygiene.

5. The senior most teachers should impart the first few sessions on the art of interviewing and history taking.

6. It was emphasised that the most important approach for health education teaching would be from patients point of view and mainly on the following considerations :

   (a) According to the patient what is he/she suffering from ?

   (b) What was the cause of his/her disease in their opinion ?

   (c) How has he/she been or would have liked to be treated ?

7. The crux of health education is largely in the art of communication so that the students on the one hand and the patients one the other are both made aware of the factors in the maintenance of good health as well as those for the loss of it.

8. Emphasis was laid on the suggestion that students be trained to integrate folkways of thinking and perception with those of science and apply them in their day-to-day work.

With regard to clinical subjects the following were the recommendations :

1. The medical curriculum should be modified to equip students to incorporate health education in every medical act.

2. To use the medical consultation :

   - for establishing a cooperative relationship;

   - to find out what patients think they are suffering from, what caused it and how they have treated it by appropriate questioning;

   - to assess the educational level of patients;

   - to make an educational diagnosis in terms of knowledge and behaviour;

   - to counsel patients on the basis of the educational diagnosis using language and illustrations;

   - to check the comprehension of the patient in terms of understanding and behaviour;

   - to record the education given and an assessment of the result obtained.

3. To standardise, where possible, information given to patients throughout the practice situation, such as diets and regimens, growth charts and hospital routines.

4. To delegate educational activities to other members of the staff and to use supervision as an educational opportunity.

5. To conduct educational group discussions among patients with similar therapeutic needs or where the group situation is more effective in modifying behaviour.

6. To organize an information system using words, illustrations, colours and intercom throughout the service for receiving of routine patients and their relatives; for explaining hospital routines and the maintenance of hygiene for incidental health information and entertainment in wards and waiting rooms.

7. To institute a mechanism such as 'discharge clinics', 'follow-up clinics' by means of which patients knowledge of the course they should follow can be checked before leaving the institution. The information fed back to the treating department, if necessary, and by which complaints and suggestions can be recorded and through which outside social agencies can be activated.

8 A student's oratorial talents need to be developed in order to enable him to handle large groups and lead the health team.

9. Specific columns for health education which takes into account the economic status, environment, diet, etc., should also be incorporated in the case sheets being used in the hospitals.

Plan of action suggested

A. The Medical Council of India be approached for the necessary modification in the curriculum of undergraduate medical education.

B. Systematic orientation programme for medical teachers at various levels be organized through workshops and continued periodically.

C. CHEB be requested to organize these programmes at regional and State levels.

D. The changes be tried in selected colleges before they are made compulsory for all colleges after ascertaining their experience and suggestions.

E. Each college should develop subject-wise health education material, *e.g.*, posters, filmstrips, flash cards, flip books, etc. Some of the materials could be developed with the help of student-nurses and interns as a part of their practical assignments. Competitions should be held for the preparation of such educational aids.

F. The clinical departments should be encouraged to organize service camps outside the hospitals in the nearby communities and involve students, interns and develop in them the appreciation of community problems and their skills in dealing with these. Health education should form an integral part of these activities.

G. In every clinical subject marks may be set aside in both theory and practical examination (5% in all clinical subjects and 25% in PSM to start with).

H. The entire plan of action should have an in-built periodic evaluation.

Appendix VII

HEALTH EDUCATION IN THE UNDER-GRADUATE MEDICAL CURRICULUM

Summary

The paper discusses the role of health education in clinical and community health services : the role of the doctor and the medical student in using health education as a diagnostic and therapeutic tool : the present situation of the teaching of health education skills to medical students in India and the communication and educational skills in which their competence should be required. Suggestions are made for modifications in the recommendations of the Medical Council of India in the undergraduate medical curriculum which would legitimize and assist colleges to integrate health education with all phases of their teaching. Notes on the objective and teaching of health education suitable for an integrated curriculum are appended.

Terminology

The term 'health education has been defined in many ways and the term 'community' is currently used in a variety of contexts and meanings.

I. For the purpose of this paper the term 'health education' comprises :

(i) Counselling individual patients : the diagnostic and communication skills a doctor uses in the clinical practice of health education.

(ii) Stimulating, guiding and coordinating the health component of the community development; the educational skills a doctor uses when partci-pating as leader of the health team.

(iii) Using the mass media for creating a climate of public opinion.

II. 'Community' means any group of people linked by a common interest hence the hosp'tal community, the village community, the factory community, the medical community, etc.

"Health is essentially an individual responsibility in the sense that, if the individual cannot be trained to take proper care of his health, no community or state programme of health services can keep him healthy. The issue is therefore basically one of education".

—*Report of the Group on Medical Education and Support Manpower*, Ministry of Health and Family Planning, Government of India, New Delhi. April 1975.

Does the present undergraduate medical curriculum equip students with the skills they require as doctors to integrate health education in every aspect of their practice as doctors ? This was the question which prompted the Ministry of Health through its Central Health Education Bureau to call together representatives of all the disciplines of medical education to consider the problem and make such recommendations as they think fit. The World Health Organization was happy to cooperate fully in this initiative.

The doctor-patient relationship consists principally of communication. The doctor's reputation may determine not only which doctor the patients choose but what system of medicine they confide in. Health education is not a substitute for technical competence. The verbal and non-verbal exchanges which occur between doctors and patients decide, to a great extent, whether their services succeed or fail.

Though doctors may think it is they who examine patients, learning is mutual between the physicians and the patients because patients also examine doctors—friendly, patronizing or arrogant ? Communicative or silent ? Self-centred or patient-centred ? Subconsciously the relationship is developed by both parties. Since this relationship determines to great extent the outcome of every medical act, the sum of all these acts determine the effectiveness and economy of the health services.

At a time when India's health services are expanding with the avowed aim of meeting the actual needs of the people, effectiveness and economy are of paramount importance. Therefore, the people responsible for teaching the medical students who will eventually serve the public, hold one of the keys to future success.

Most teachers will agree that in educating medical students' professional standards must be maintained but the substance of professional competence will constantly change to accommodate technological progress and the service needs of the foreseeable future.

If the technological progress of recent years changes, it is to benefit the mass of the people, it must be matched by an equivalent of attitude, function and organization in the service sector.

The enlightened participation of the people in managing their problems of health and sickness is the most powerful latent resource in the hands of the health services. Is the future generation of doctors and health service administrators being prepared to grasp this opportunity ?

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THE BACKGROUND

Health education under various names has been carried out by a variety of people since the dawn of society. Priests, folk practitioners, poets, pharmacists and rulers have all influenced the health consciousness of their time. With the emergence of a scientific approach in medicine and other social disciplines, health education has been able to draw on new knowledge about human behaviour which has made it a more precise tool in the hands of all health workers with all the ethical considerations that implies. In the rich culture of India the past and present mingle like the ox cart and the satellite. Health beliefs and customs of all periods rub shoulders in most of its communities. People are keen to accept modern services if they are available and do not cause much inconvenience in their pattern of life. Health is frequently the subject of the newspaper articles and editorial comments and is now one of the most popular themes of the mass media which, for better or for worse, indicates the importance the profession should attach to its proper use.

The medical student of today

Medical students come mainly from urban middle class families. Their parents have a high educational status. The majority choose a medical carrier before the age of sixteen and there is some evidence that their motivation for entering the profession is shifting towards human rather than scientific or material interests. The majority complete their medical studies and approximately 12,000 graduate annually. Their reaction to social and preventive medicine as it is taught today is frequently negative on the grounds that it is academic and lacks practical application. Like Aesculapius who had two daughters Hydeia and Panacea they tend to prefer Panacea. Study of the effect that medical education has on the motivation of medical students has been started and should provide the barometer with which the curriculum can be assessed.

Every student from time to time wonders why patients (or people in general) behave the way they do about health and sickness. Why do women risk self-abortion when they can get it safely and free of charge ? Why does that tuberculous young man fail to take his medicine regularly ? Depending on their temperaments they may joke, think seriously about it or brush it under their emotional carpets. They feel at home with the antigen-antibody response; they have revealed the secrets of the mosquitos' salivary glands; they know all the theories about schizophrenia; they may even have some strong views about the environments in which these dramas are enacted but the behaviour of ordinary patients as people remains vague and troublesome. What they learn about behaviour as medical students does not seem to apply to the people they encounter.

If they feel concerned, they may start by trying to tell patients what to do and even apply 'doctors orders' to improve their behaviour on the assumption that patient will carry them out; or they have a consolation they have done their bit and their conscience are clear. Failure on the patients' part may produce in them (doctors) frustration, a feeling that it is a waste of time or hopefully a lively curiosity. They may start by blaming the patients' ignorance or poverty, they may accuse the authorities of negligence or society for its indifference. But at some

time they may also search their own experience for clues to their own behaviour. Why does he (doctor) continue to smoke when he knows its adverse effects ? Why can't she change her father's attitude to her marriage ? Why do they tolerate the mess in the canteen ?

It is at this point that the students can experience the critical change of attitude, so often referred to, which enables them accept patients as people in a social setting, with behaviour patterns as relevant to their illness and to their recovery as the gonococcus or the adjustment of their blood chemistry.

What we may describe as educational diagnosis and educational therapy, which form such an important part of the management of a case with a few notable exceptions, are rarely taught by clinicians, and most students are left unaware of the need and the methods of tackling them. One of the reasons is certainly that the importance of behaviour in the etiology of disease has not been considered sufficiently seriously. There is no mention in the textbooks. Another is that learning the skills required can only come about by thorough and repeated practice in the real life situation. For a variety of reasons teachers find this more difficult to provide them theoretical or laboratory study.

Health education like much of medicine is an art which draws on science but resides in the hands of the artist. It cannot be learned theoretically any more than surgery. First attempts may be crude; refinement and economy only develop with use.

While learning to practise health education, students have to extend the parameters of their understanding of the human condition. In doing so they become motivated to break the vicious circle of poverty, apathy and disease. They begin to understand the economic and personal reasons for people's acceptance of not utilising the services status quo. They learn to use the technical and social means at their disposal for intervening with skill and precision. They learn to pinpoint the behaviour patterns, the outside pressures and the social conditions on which the viciousness of the circle depends and to use the technical, educational and political position with which society has favoured them to catalyse change.

For carrying out any action, we must know what we ought to do, have the will and the means to do it, and the courage to face the consequences. Teachers can help students, and doctors can help patients to identify that it is necessary for them to do and motivate them to do it; they can teach them the necessary skills and help find the resources, they can support those who encounter difficulties and reinforce their resolve.

Such an additional burden on the busy life of a teacher may seem excessive, but if students are trained from the outset, stage by stage, to integrate health education with whatever they are studying they will find that it becomes a reflex and need not take more time. Teachers will soon recognise that the rewards it brings to them and their students make it worth the extra effort.

Doctor as teacher

The educational role of the physician has always been latent in the popular image of the doctor as a 'guide, philosopher and friend' and was embodied in

the medical profession's image of itself when it chose the title of doctor because in the Latin, from which this title comes, Doctor means Teacher.

To answer the basic question whether students are being taught to use this powerful tool, it is necessary to examine the pronouncements of those responsible for medical education from the Bhore Committee of 1946 to the most recent recommendations of the Medical Council of India in 1978; to study the findings of the Indian behavioural scientists; to examine the conclusions numerous Workshops of professional people in executive positions have reached; how the recommendations have been put into practice by medical colleges and to inquire whether development of skills of health education forms part of the qualifying examination in medicine.

In preparation for this Workshop, the CHEB sent a questionnaire to 96 medical colleges to ascertain the status of health education in their curricula. 60 replies were received from this sample; it appears from these that some health education is taught in all these colleges but the time devoted to it ranges from 1—10 hours of theory and nil to 72 hours of practice.

The practical training in health education is located in families (5), at field visits (8), school and urban slums (2), wards, (1) PP programme (1), Integrated (5), not specified (24).

Subjects in which health education is included

Obst. & Gynae. (7), MCH & Nutrition (1), Clinical and Social Medicine (4), Paediatrics (7), National Health Programmes (1), OPD (2), Medicine (3), Surgery (1), Family Health (11), Sanitation (3).

Faculty

37 Colleges had appointed a staff member to teach health education.

Qualifications of the Health Educator

Diploma in Health Education (15)

Other qualifications (11)

No qualifications (11)

Among 'remarks' the colleges mentioned that students were interested that they wished to develop an integrated programme involving the whole hospital; hold workshops on the teaching of health education in the medical curriculum; the value of the internship period, of students living with families and the use of preventive medicine camps for the practice of health education.

Though these replies may not truly represent the situation, they indicate that health education in the undergraduate medical curriculum has developed in a few colleges which have integrated it with all the subjects taught but that in the majority it is not integrated or has been developed as a minor aspect of SPM. In a few, health education appears to play no part in the student's studies. Nowhere, does health education figure in the clinical examination.

In summary, it is clear that India has given mcuh thought to the problem of extending health services to cover the entire population and has committed itself to achieve health services for all by the year 2,000. Many sound recommendations have been made and some mutual colleges have shown initiative.

How can these lofty aspirations be achieved ? We are here concerned with a small but vital sector of this gigantic operation, the preparation of the citizens and professional people on whose will and competence the rate of progress depends. The public is not satisfied with the capacity of the health services to cope with the actual health problems of the mass of the population. Thoughtful members of the medical profession are equally dissatisfied, and are proposing a variety of evolutionary or radical changes in the provision of health care and the type of training health workers require to provide the services. There is no lack of awareness among the health authorities of the shortcomings, and potential of the resources at their disposal. Among medical educators, there are many with a lively interest in how to prepare a basic doctor to meet the actual needs of the vast majority of the population but as yet the preparation students receive in the vital sector of health education is deficient.

Whatever developments occur in the provision of health services and their extension to the entire population, competence in the art of communication between doctors, patients and population at large is and will remain the oil which allows the mechanism to work. Why has training in these skills been neglected in the curricula of the vast majority of medical schools throughout the world ?

A variety of parochial reasons are repeated everywhere such as lack of time and lack of staff, lack of opportunity in the over-worked conditions of medical practice, the greater attraction of new technology, insidious pressure from drug companies and other vested interests in the *status quo* which condition both patients and doctors to seek instant salvation in the syrings or pill. There are certainly difficulties but they fall within the ambit of the Universal Laws of that famous wit Professor Parkinson, who would no doubt summarise the situation in three new Laws. Law I. "Curricula grow to fill the time made available by the Grant Commission", Law 2. "Curricula are always overcrowded", Law 3. "Curricula reflect the weighted average of the teaching faculty".

The reason lies deeper and India has stated it more clearly and eloquently than most countries. It is the attitude in society, its administrators and professionals towards the role ordinary men and women can play in solving their own problems, and the priority given to this role in the planning of services and the preparation of the staff who will man them.

There is still a philosophical conflict over the relationship between education and service in the faculties of most universities.

Working back from what basic doctors actually do in clinical and public health practice few would deny that the time allotted to the existing subjects may need revision and that preventive and social aspects need more emphasis. Something has already been done to bring this about. The content and approach of health education related to all clinical and public health teaching needs spelling out but the main changes which will have to be considered are the methods of

teaching which link learning with service. These steps may reveal areas where research is necessary.

An old dimension of medical practice renewed

The Recommendations of the Medical Council of India go a long way to legitimise curriculum reforms which would enable medical colleges to prepare students with a more social orientation. Some colleges have taken the initiative of providing experiences for their students which effectively integrate health education with the community health services they provide.

However, as the Srivastava Committee points out health is essentially an individual matter. In India 180 million patients see doctors individually as out-patients and 80 million individuals spend an average of 7 days in hospital as inpatients. Is this vast potential for health education recognised in undergraduate medical education ? Is the hospital and the health centre used as the educational institution its place in the community merits.

It is evident that a theoretical appreciation of the importance of health education is fairly widespread in the recommendations for social and preventive medicine but the applied aspects particularly in clinical medicine have been left extremely vague. The terminology derived from the behavioural sciences may be partly responsible as it seems indigestible to medical people accustomed to their own professional concepts and vocabulary. Constraints of staff, time and field facilities may all contribute to the delay in integrating health education with the main stream of medical practice.

It is one of the purposes of this Workshop to suggest how they may be overcome. It we analyse the basic competences a doctor needs to carry out his work properly a high proportion concern skill in communication with individuals and groups of various kinds.

Let us consider for example the fundamental procedure of the art of medicine; the Medical Consultation which involves :

(1) The use of language appropriate to the patients' understanding;
(2) The establishment of rapport when receiving patients and terminating interviews;
(3) Diagnostic listening and questioning—history symptoms etc.;
(4) Observation and physical examination;
(5) Synthesising the information gathered with a view to diagnosis and prognosis;
(6) Treatment planning—pharmacological, behavioural, nutritional and social;
(7) Explanation—verbal and graphic;
(8 Therapeutic and preventive counselling;
(9) Checking comprehension in terms of the patients understanding and behaviour;
(10) Recording the actions and advice given for use by other practitioners.

From the above list of steps in a consulation it is clear that all of them depend o a greater or lesser extent on the communication skill of the practitioner. The constraint of time makes it even more important that the practitioner accomplishes his task with maximum efficiency. For this he will require much practice.

Language

In India where medical education is conducted in English a language gap most likely exists between doctors and patients which can reduce the value of the information gathered and the counselling given. Symptoms and even history should be recorded as spoken by the patient. The explanation of the diagnosis and therapeutic and preventive counselling must be given in the language used by the patient which may cause difficulty for the unpractised mind.

Diagnostic listening implies patience and a selection of the information the doctor needs and the mastery of the art of asking questions economically is perhaps the most important communication skill as Plato so ably demonstrated in the Socratic dialogues. The way questions are asked influences the quality of the answer and consequently the information gathered. Patients may bias the answer to offer what they think the doctor wants to hear or miss the point of a question they do not properly understand. For health education purposes two or three questions should always be asked of the patient : What do *you* think you are suffering from ? What do *you* think caused it ? and if relevant How have you been treating it ? The answers to the first two questions can give the doctor invaluable insight into the patients' belief, anxieties, suspicions and ideas on etiology which are the points of departure for any useful explanation and reassurance later. The third question may reveal much about the therapeutic beliefs in the patients milieu. *Observation* in addition to the physical characteristics as personal care or handling of a baby communicate non verbally behavioural characteristics and psychological overtone. Tears, hesitation or tremor should communicate to the doctor the emotional significance of what the patient is describing and help him to choose his educational tone.

The *physical examination* may reveal much about the body image of the patient. It provides time to talk and even to draw on the skin with a grease pencil the organ concerned or in the case of a pregnant woman the foetus in utero.

Explanation and counselling start where the patient is and lead to where the doctor thinks the patient should get. It need not be entirely rational and skill in using the patients beliefs to achieve useful behaviour can only be learned by thorough practice. Technique of following a brief counselling by asking the patient how he or she is going to carry out what the doctor recommends is a most powerful educational approach which checks comprehension and at the same time produces a measure of commitment on the patients' part.

Standardised information

There is much information which can be standardized particularly in hospitals where the patient will encounter a variety of counsellors; patients communicate

most effectively with people of their own background and it may be the cleaners advice which is eventually followed. Diets can be standardised for most conditions in which they are of importance such as slimming, diabetes, pregnancy, etc. The management of other conditions such as cardio vascular disease, tuberculosis or the bandaging of a varicose ulcer can also be standardised for the majority of cases. Such standard advice agreed among the medical staff should be translated into the vernacular and suitably illustrated. This in itself is a valuable educational exercise for the staff. It should then be tested on a sample of patients and the language and illustrations revised in accordance with their comments. It should be printed on durable cards of a standard size. Such cards can be put to three uses : circulated to the entire hospital where they can be kept in wards and outpatient departments and used by the staff, given by the treating doctor personally to the patient to reinforce advice and used for inservice staff training. The doctor giving the card or another attendant should impress on the patient its importance and if the patient is illiterate explain the illustrations and encourage the patient to get some literate person to read it for him. In common conditions such cards can have a useful multiplier effect as they have the authority of a respected institution and will be discussed among families and friends.

The exploitation of the opportunities provided by a medical consultation and information may be carried out in a variety of ways and in cooperation with other staff members but the dcctors role is cardinal and cannot be omitted as he is the person the patient came to see and his authority has a specific educational weight. With practice and experience the addition of the educational dimension to the consultation need not take more time and by increasing the effectiveness of treatment and increasing the patients satisfaction can reduce substantially the patient load. The educated diabetic is less likely to return in coma and the educated mother less likely to let her child relapse.

In the recommendations of the Medical Council of India the references to health education in many paragraphs dealing with social and preventive medicine should be adequate guidance for curriculum planners and teaching staff. However, the omission of any reference to health education in the curricula of the clinical disciplines of medicine, surgery, obstetrics and gynaecology, paediatrics, eye and ENT which are primarily reponsible for the management of individual cases could lead curriculum planners and teachers to consider it had no place there. Among the practical skills of clinical medicine listed on page sixteen of the recommendations again no reference is made to the communication skill which form such an important part of medical consultation, patient counselling and rehabilitation. This omission may be important because it is precisely in the handling of these basic skills of medicine that misunderstandings are likely to occur leading to frustration of both doctor and patient and of the success of the medical intervention. Understanding the principles of health education as mentioned in the recommendations (Appendix B page 43 (g) is no substitute for its daily practice at the bedside and during every medical act.

Examinations

If health education has been integrated with all the subjects of the medical curriculum and teachers have set an example it should be obvious to students

that its practice is useful and interesting. However, it is normal that as examinations approach the majority of students will concentrate their attention on what they estimate their teaches are likely to ask. If they know that the health education aspect of any question will attract marks or may even lead to failure if not adequately dealt with their interest in acquiring its skill will be heightened.

Conclusion

It would appear therefore that with greater emphasis on service experience useful guidance is given by the IMC recommendations to develop a sound practical and theoretical programme of teaching in health education for the community and environmental aspects of a doctor's work but that guidance for the teaching of its clinical application has been overlooked. Learning by practising the skills of health education takes time and should start during the preclinical stage and be developed step by step with all the substantive subjects.

Curriculum committee proposals

In preparation for a National Workshop the Central Health Education Bureau invited faculty members from the four Delhi medical colleges to assist them in preparing the background material for this meeting. The small curriculum group including a dean and professors, associate and assistant professors from the colleges was assisted by staff of the CHEB and the Regional Adviser in Health Education and a consultant from WHO. Together their experience covered the fields of medicine, surgery, radiology, obstetrics and gynaecology, PSM, paediatrics and health education.

The group considered the present position of health education in the medical curriculum : the skills and knowledge students require in order to integrate health education with the practice of medicine : the extent to which the recommendations of the medical Council of India cater for the acquisition of these skills : the way in which an integrated curriculum should be constructed covering (1) Clinical and Preventive Medicine; (2) Community and Environmental Health : who should teach the integrated subject : how should the teachers be prepared and how the skills and theory of health education should be tested by examination.

The group met for ten hours in December 1978 and came to the following conclusions :

(Health education should be taught as an integral part of preclinical, para-clinical, clinical and intern disciplines and not as a separate subject. Competence should be examined by treating it as a substantive part of any question in the examination papers or in the viva voce where it was relevant. Marks should be awarded in relation to the importance of the health education component in the answer.

As regards the teaching of the communication skills which were common to all aspects of medical practice the group considered that these should be spelled out, taught and examined systematically. A specific suggestion was made that

they should appear as a separate paragraph in the recommendations of the M.C.I. (p. 13) section IX, Phase III immediately preceding the heading "Medicine".

Draft modifications of the recommendations of the Medical Council of India as approved by the group should be submitted to the National Workshop for discussion and action (see *Annexure* 1).

In view of the shortage of time and the complexity of the task the secretariat of the CHEB. and the WHO Consultant should be requested to prepare a draft curriculum integrating the practice and theory of health education with all the disciplines of the curriculum to the extent to which they are relevant and provide illustrative examples wherever possible of the usefulness to patients and students of such additions. Some examples of experiments which medical colleges could carry out should also be suggested.

The teaching of health education should be done primarily by the teacher responsible for the substantive aspects of the subject being taught. Clinical teachers should be responsible for the application of health education in the management of disease and its prevention, SPM teachers for its application in community participation and the promotion of health in the community.

Time did not permit the group to consider in any depth how the faculty members could be prepared to integrate health education with their teaching nor to consider the contribution of the health education specialist but recognised that this was an important area in which the Central Health Education Bureau should be prepared to assist medical colleges.

The group also considered that the Medical Council of India insist that the examination in preventive and social medicine which includes health education remain at the final professional level carrying equivalent marks to medicine or surgery.

Annexure I to Appendix VII

DRAFT MODIFICATIONS TO THE RECOMMENDATIONS OF THE MEDICAL COUNCIL OF INDIA ON UNDERGRADUATE MEDICAL EDUCATION— 1977-78 AS PREPARED BY THE CURRICULUM ADVISORY COMMITTEE AT THE INVITATION OF C. H. E. B.

List of members of the Curriculum Committee

1. Dr. P.V. Gulati — *Chairman*
   Prof. of P.S.M.
   Lady Hardinge Medical College
   New Delhi.

2. Dr. (Smt.) S. Chawla
   Principal & Medical Superintendent
   Lady Hardinge Medical College & Associated Hospitals
   New Delhi.

3. Dr. (Smt.) V.V. Gujral
   Prof. of Pediatrics & Head of the Dept of Pediatrics & Rehabilitation,
   Kalawati Saran Children's Hospital
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The Committee proposed that the recommendations of the Medical Council of India, 1977-78 be amended as follows :

Article IV page 7 states (1) The objective of producing a medical graduate... capable of functioning *independently* and effectively in rural and urban settings shall be kept in view throughout the course.

Proposal : "independently" should be amplified by "and as a member of a team".

(2) states.....the educational process should be more community based than hospital based.

Proposal : add "The hospital is a major community asset for the provision of thealth services. The extension of its services into the community should be fully used for teaching medical students and educating the public.

Page 8(7). Throughout the medical course one nour a week should be devoted to inter departmental teaching.....for these sessions the main emphasis should be on the aplied aspects of the subject.

Proposal : following "applied aspects of the subject" add including health education as applied to an individual, a group or a community with a view to bringing about integration of the teaching of the departments and facilitating understanding by the student of the role of various disciplines in the total health care of the community.

Page 8(11) states every attempt should be made to develop personality, character, expression.....and other faculties etc.

Proposal : add "educational skill" between "expression" and "other faculties."

Page 11 4(d)

Proposal : add "and community" immediately following the word "patients".

Page 13 article IX

Proposal : The following paragraph should be inserted immediately below the heading :

"The basic skills of medical practice common to all the clinical disciplines should be taught by systematic demonstration and practice and should be tested by examination.

Students' competence should be ensured in :
All aspects of clinical consultation : practice organization and management; education of patients and staff : the promotion of health in the community.

(c) Proposal : add "including education of the patient and the family".

(e) Proposal : before the "etc." add "and the use of the ward for health education".

f, g, h *Proposal* : three paras should be added :

(f) Instruction in the use of O.P.Ds for educational purposes.

(g) The role of nurses and other attendants in reinforcing the educational aspects of treatment and the use of hospital facilities.

(i) The standardisation of advice where appropriate.

Page 14 Proposal : Between paras (g) and (h) a new paragraph should be inserted : "Prevention of accidents and other surgical conditions and the educational aspects of rehabilitation."

Page 14 3

(b) Proposal : add "including education of the patient and the parents".

Page 14 c Proposal : add "iv" following the word "out-patient and the related health education practice".

Page 15 (b) Proposal : Following the words "post natal observation" should be added "on account of the advice given regarding contraception".

Page 15 4 Paediatrics :

Proposal : The paragraph should conclude with "education of parents in child care and rehabilitation."

Page 15 5 Eye and ENT

Proposal : The paragraph should conclude with "and education of the patient and his family in the prevention and early detection of eye and ENT conditions"

Page 22 3 End of phase III

Proposal : (a) medicine : include health education in the list of subjects mentioned

(b) Surgery : ditto

Page 25 5 after the word "clinical" add "educational and community"

Page 27 Department of Medicine

Proposal : A fifth item should be added "They should participate in the education of patients and their families"

Department of Surgery (b) ditto

Department of Obst. and Gyn. 7 ditto

Page 28 b Proposal : A last item should be added "staff training"

Page 29 Teacher training

Proposal : Between present items 1 and 2 should be inserted "methods of integrating health education in the total health management of individuals, families and the community".

Page 39 i

Proposal : add at the end of this para "and in educational diagnosis and treatment"

Page 40 (b) Proposal : The first item should be "doctor patient communication".

Page 42 (g)

Proposal : Add the words "practice & ethics" after the word "Principles".

43 (i) Top para

Proposal : This paragraph should conclude with "As much emphasis should be given to the behaviour as to the disease patterns of the community".

Annexure 2 to Appendix VII

HEALTH EDUCATION IN THE UNDERGRADUATE MEDICAL EDUCATION

Notes on an integrared curriculum*

Terminology

For the purpose of these notes an integrated curriculum is one in which two or more subjects previously considered separate are interwoven to become inter-dependent and are taught simultaneously. Since integration generally takes place more easily within people than between people, these notes assume that the teacher responsible for the curriculum subject—Anatomy, Medicine, SPM, etc.—will also be responsible for teaching its health education aspects as a single entity.

Health education may be defined as *a state of health consciousness* in a person, a family or in society which expresses itself in accepted norms for health behaviour and for the environment.

A process of learning and teaching which enlightens health workers about the health behaviour of patients families and the public and which equips people with the knowledge, desire and skill to make reasoned choices in health and sickness and to act on them.

A relationship of trust and cooperation between health workers and lay people in promoting health, preventing disease, treating and rehabilitating the sick.

Within the context of these notes health education in medical practice means :

Counselling individual patients : the diagnostic and communication skills a doctor uses for health education in clinical practice.

Stimulating, guiding and coordinating the health component of community development : the educational and social skills a doctor uses when participating in community activities as a health expert.

*These notes were prepared by CHEB in response to a suggestion of its curriculum advisory group thht such notes should form part of the background documentation of a national workshop.

Using the mass media for educational purpose and creating a climate of opinion.

Some considerations in designing an integrated curriculum

Health education in medical practice is still in its infancy and its medical and educational parents have not yet fully grasped its potential. As a result its place in medical education has been vague and somewhat isolated.

These notes are not intended to offer a blueprint for integrating health education with teaching of medicine but to help curriculum committees to spell out in functional terms the role of health education in the various medical disciplines and develop a programme of studies which suits their local circumstances.

In the present state of the art students can assist curriculum committees by identifying the health education component of their clinical and community work and interpreting the roles of other health professionals particularly the health education specialist in the team which they may be called upon to lead.

Motivation : The motivation of students should be the prime concern of the curriculum committee. The evidence from India and other parts of the world suggests that the motivation of students embarking on medical studies responds and develops in direct relationship with practice in rendering service to people.

Health education can be an important factor in enhancing motivation. On the one hand it brings students into direct relationships with patients as people rather than cases and on the other it helps them deal with their own student health problems which range from nutrition through methods of study, sexual relations, etc. to anxieties caused by the dissecting room; the diseases they encounter for the first time, their own hypochondria and the inevitable "examinitis" summed up as MSD.

Health education can be an important means of sustaining motivation during a long period of study.

Theory and practice : A second curriculum consideration is the balance between theory and practice. Theory unrelated to practice rarely results in competence and practice unsustained by theory leads to stagnation. However, in an applied art such as health education practice takes precedence and since the acquisition of necessary skills takes time they should be introduced at the outset and with scope for trial and error.

It is generally found that practical experience in service conditions is a strong stimulus to theoretical study and curriculum committee may wish to consider how to reverse the usual order and introduce practice before theory.

Creating a purposeful curriculum for the special conditions of medical practice will require a systematic approach, experimentation and a more sophisticated understanding of the patients role in the doctor/patient relationship and the management of health and disease. It will also require the simplification of techniques which can be applied in the actual conditions and which can be mastered by the average student.

Though some principles of human behaviour in health and sickness have emerged as a result of experience and research they are generally the product of a particular culture and may not apply in the local setting. Unlike scientific or mechanical principles which are more or less universally applicable the principles of health education are tied to the local circumstances in the same way as language, customs and resources.

The content and methods of health education taught to medical students should therefore concentrate on local problems and the basic skills of communication in as wide a range of circumstances as the local situation can provide. Theoretical study should not exclude other relevant culture patterns as these will enlarge student frames of reference and encourage flexibility but they should not be used as models.

Questions for the chairman of a curriculum committee

The chairman of a curriculum committee may find the following questions useful in discussing with his colleagues the integration of health education with their particular field of work.

The curriculum in general

What motivation have the students when embarking on the programme of studies and will the studies maintain and enhance this motivation ?

Does the curriculum ensure that the students are competent to practice the essential skills of health education in the service conditions prevailing ?

Individual patients

What are the particular features of establishing a cooperative relationship between doctor, patients and families in each discipline ?

What are the basic communication skills required in medical practice ?

What language problems arise in communication between doctor and patients ?

What kinds of questions closed ended or open ended produce the most useful answers for the management of particular conditions ?

How should a doctor handle agreement or disagreement with what the patient thinks so that confidence and respect are maintained ?

What is the essential content matter that the patient should understand in order to cooperate in recovery and the prevention of relapse or spread ?

How best can this be communicated by questions, instructions, group discussions or by visual means ?

How can a doctor check the understanding of a patient about his condition, its management and his responsibility for others ?

Can the educational diagnosis and treatment be recorded for use by other doctors ?

Community health

What conditions require community action for their prevention ? How can a doctor intervene ? What educational approaches are most effective in each specific intervention and how can this be evaluated ?

What role has the doctor as a health education specialist in a community, as the manager of the health team ? How can a doctor translate his knowledge into action ?

Examinations

How can educational component be linked with the substantive questions in examinations and how should it be marked ?

Sample objectives for the health education component of medical studies

It is customary in education to state the objectives of teaching in terms of the students understanding and the practical abilities with which their studies should equip them. In medical education this discipline is most useful both for teachers and for students as it brings out clearly what is expected of both parties and allows for fair and objective evaluation during the course and at the final examination.

The following tentative examples are given for the health education component of the substantive disciplines enumerated in the Recommendations of the Medical Council of India (1977-78).

Anatomy, embryology, histology and genetics

Sample Objectives :

To equip students

1. To explain in the language used by patients, 6th grade school children and first aid volunteers (a) the structure of the human body and the individual organs genitalia, lungs, heart, bones, joints, etc. (b) the development of the human body from conception through foetal development to adulthood, and (c) the genetic factors determining structure.

2. To illustrate the explanation with lightning sketches or other prepared material.

3. To discuss controvertial anatomical and developmental questions of interest to the public particularly concerning genetics.

4. To understand the significance of the "body image"* to themselves and to patients : thin-ness-fatness; beauty-uginess, strength-weakness, disfigurement, etc., and its application in conneution with breast feeding, mastectomy, giving and receiving blood, vasectomy and fallopian ligation, etc.

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* "Body image" may be def.ned as how one pictures the body in one's mind's eye and how one feels about it.

Human Physiology

Sample Objectives

To equip students :

1. To explain in the language used by patients, 6th grade school children and first aid volunteers the functioning of the principal systems of the human body -heart, lungs, elementary system, evacuation of waste products, blood compatibility, effects of giving and receiving blood, etc.

2. To understand their own ideas on the normal in sexuality, fecundity, growth, working capacity, etc., and the application of the concept of normal to medical practice.

3. To understand the functions attributed to the various systems by folk beliefs and patients concepts of the normal, with particular reference to sex and family planning, nutrition, the growth and development of children, energy, pain and departures from the normal such as disease aging etc.

Biochemistry

Sample Objectives

To equip students :

1. To explain the common biochemical of tests to patients in the language used by them.

2. To understand the objections of patients to taking samples, particularly of blood, the methods most effective in and gaining their cooperation.

Psychology

Sample Objectives

To equip students :

1. To understand the psychology and use appropriately the language of their clients in speech and in writing.

2. To understand and use appropriately all the communication skills required for diagnosis and case management with patients, their families and the community.

3. To understand and use appropriately the various types of questions required in the consultation process; the types of response they produce and their educational potential.

4. To understand and use appropriately the psychology of groups for educational purposes.

5. To understant and use appropriately the psychology of mass communication based on Indian experience.

6. To understand the basis of human relationships in the local setting and to demonstrate respect and concern in their behaviour with patients, families and the public.

7. To understand motivation and to practise the skills of finding out the reasons for which patients, families and the public are most likely to take action or modify their behaviour : the role in motivation of instincts, drives, family and social pressures, the doctors authority and material incentives.

8. To understand the basis of perception and to experiment on themselves and in the class with sensory perception, projection, recall and interpretation.

9. To integrate folk ways of thinking and perceiving with those of science and applying them particularly to family planning, pregnancy, nutrition, the prevention of communicable disease and hygiene.

Nutrition

Sample Objectives

To equip students :

1. To ascertain the food and cooking customs of patients and families, the role of food hygiene in disease causation in the locality.

2. To explain to patients the use to which the body puts the food consumed in terms of growth, energy, protection from anaemia and other forms of malnutrition, particularly of infants and young children and the role of water in nutrition.

3. To prescribe diets composed of cheap local foods rich in proteins, minerals and vitamins and the methods of preparing and cooking hygienically. To arrange for practical demonstrations and follow-up.

4. To plan long-term educational arrangements for mothers to acquire sound food habits in the circumstances in which they live.

Community medicine

Sample Objectives

To equip students :

1. To understand how a community is composed and how it functions : family, class, caste, resources and environment, communication patterns, formal education, conflict and cooperation, politics and administration : leadership formal and informal.

2. To ascertain the objective health status and the modern or indigenous health services available.

3. To ascertain the level of health consciousness in the community and the epidemiology of local health beliefs and customs by survey combined with service.

4. To participate in existing religious, political or administrative groups as a health expert and educator.

5. To assist such groups to select priorities for action, based on recognized local needs and to formulate these as objectives with selected indicators of progress which reflect changes in health status and health behaviour.

6. To assist such groups to mobilize local resources and to call on outside resources provided by State or national programmes.

7. To record events and evaluate the work based on the objectives and indicators and to note other changes not included in the objectives.

8. To feed the information back to the community by appropriate means.

9. To incorporate the health component in the totality of ongoing community development.

10. To manage a practice in outpatients, rural health centres and the private sector.

11. To work as a member of a team and to select which educational activities each member is best placed to undertake. To make full use of the health education specialist.

12. To train staff for their educational role by making full use of the practical experience provided by the service conditions in which the team is working.

13. To use supervision as an educational method.

Pathology and microbiology

Sample Objectives

To equip students :

1. To recognize folk beliefs concerning pathology and the natural history of disease : to reconcile them where possible with modern scientific concepts and to explain the pathological process or the microbiological agent in terms and in the language the patient or the community uses.

Pharmacology

Sample Objectives

To equip students :

1. To identify the drugs commonly used for self-medication by patients and in the community and to classify them as beneficial, harmless or dangerous.

2. To select indigenous drugs of known activity and substitute them for manufactured products.

3. To explain in appropriate language the action of prescribed drugs and the regimen for taking them, their side effects and their danger to children.

4. To discourage requests for drugs for conditions which canbe managed by dietary or educational means particularly during pregnancy and in childhood.

5. To counteract the abuse of drugs by indepth counselling and social adjustment.

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All clinical subjects

Sample Objectives

To equip students :

1. To incorporate health education in every medical act.

2. To use the medical consultation for :

   (a) establishing a cooperative relationship;

   (b) to find out what patients think they are suffering from, what caused it and how they have treated it, by appropriate questioning;

   (c) to assess the educational level of patients;

   (d) to make an educational diagnosis in terms of knowledge and behaviour;

   (e) to counsel patients on the basis of the educational diagnosis using language and illustration;

   (f) to check the comprehension of the patient in terms of understanding and behaviour;

   (g) To record the education given and an assessment of the result obtained;

3. To standardise where possible information given to patients throughout the practice situation, for example, diets and regimens, growth charts and hospital routines.

4. To delegate educational activities to other members of the staff and to use supervision as an educational opportunity.

5. To conduct educational group discussions among patients with similar therapeutic needs or where the group situation is more effective in modifying behaviour.

6. To organize an information system using words, illustrations, colours and intercom throughout the service for receiving and routing patients and their relatives; for explaining hospital routines and the maintenance of hygiene; for incidental health information and entertainment in wards and waiting rooms.

7. To institute a mechanism such as an Almoner or "discharge clinic" by means of which patients knowledge of the course they should follow can be checked before leaving the institution, the information fed back to the treating department, if necessary, and by which complaints and suggestions can be recorded and through which outside social agencies can be activated.

Medicine

To the general objectives for health education in the clinical disciplines the following specific objectives may be added :

Sample Objectives

To equip students :

1. To identify the educational component in the common diseases seen in practice.

2. To decide on the content of the education required for managing the condition or preventing relapse and spread.

3. To adapt the content to suit the belief system, comprehension and material situation of the patient and the family.

Surgery

To the general objectives common to all clinical subjects the following specific objectives may be added :

Sample Objectives

To equip students :

1. To ascertain and associate themselves with the "body image"* of their patients in relation to surgical conditions and to early detection of signs with particular reference to tumours, bleeding, pain and surgical procedures such as mastectomy, the pinning of fractures, anaesthesia and scarring.

2. To discuss with patients and their families using appropriate illustrations surgical interventions proposed and to gain their acceptance.

3. To use the facilities of the department for educating patients and their relatives regarding the prevention of accidents in the home, at work and on the roads.

4. To teach as appropriate the early symptoms and signs of surgical conditions and to demonstrate breast self-examination.

5. To encourage the relatives of all patients to give blood.

6. To gain the cooperation of patients and their families in relevant mesures for rehabilitation and to organize, in collaboration with other attendants, the educational programme.

Obstetrics and gynaecology, family planning and nutrition

To the general objectives of the clinical disciplines may be added :

Sample Objectives

To equip students :

1. To prepare the mother and her family mentally for child birth, breast feeding, the hygiene of birth and the post-natal period including if appropriate sterilization of herself and/or her husband bearing in mind her body image.

*The mental picture a person has built up his or her own body.

2. To introduce the mother to the developing foetus by allowing her to listen to the heartbeat and drawing the foetus on the abdomen with a grease pencil. To discuss her anxieties.

3. To educate mothers about breast-feeding by discussing their anxieties if necessary and demonstrate the milk flow.

4. To reinforce this education by enlisting the support of her husband and family.

Paediatrics

To the general objectives common to all clinical disciplines may be added :

Sample Objectives

To equip students :

1. To create a pleasant relationship with mother and child.

2. To explain normal growth and development and answer all questions in appropriate language.

3. To educate the mother and her family regarding nutrition at relevant ages based on locally available cheap foods and safe water : how to prepare them using her own utensils and in an hygienic manner.

4. To educate the mother and her family regarding immunization and protection from worm infestations, scabies, mosquitoes and accidents.

5. To instruct mothers with practical demonstrations how to render first aid to a child after accidents, how to treat diarrhoea or fever and prevent dehydration using her own resources; when to see a doctor.

6. To teach mothers how to detect early signs of illness such as T.B., Leprosy, Malnutrition, Scabies.

Ophthalmology

To the objectives common to all clinical disciplines add

Sample Objectives

To equip students :

1. To teach mothers how to detect early symptoms of visual defects, eye diseases such as trachoma or injuries to the eye and when to seek medical attention.

E.N.T.

To the objectives common to all clinical disciplines add :

H.E. Objectives

To equip students :

1. To teach mothers to detect early signs of inflammation of the middle ear.

The intern phase

Sample Objectives

To arrange postings which enable interns :

1. To practise the educational skills they have learned regarding sickness and its prevention for individuals, families and the community.
2. To take responsibility for the educational component of programme planning, staff training and supervision, implementation and evaluation essential to the health contribution to community development.
3. To evaluate the experience with the intern and feed it back to the curriculum.

In practice these tentative objectives will need refining in the light of experience to focus on what the teacher considers essential understanding or skill in the particular discipline. Reviewing the experience and motivation of interns is likely to be the most valuable guide to the strengths and weakness of the teaching programme. This is best done during the posting and in free group discussion at the end of the appointment.

WORKSHOP ON POST-GRADUATE DIPLOMA COURSE IN HEALTH EDUCATION

(June 3 — 29, 1974)

(Special Working Group to Prepare Curriculum in Health Education for Medical under-graduate).

The Gandhigram Institute of Rural Health & Family Planning, Gandhigram.

Participants :

Chairman : Dr. B.N. Ghosh,
Rapporteur : Dr. Vijaya Srinivasan

Members :

1. Dr. V. Benjamin : Professor & Head of the Department of Community Medicine, Christian Medical College, Vellore.
2. Dr. S.A. Kabir : Professor of Preventive & Social Medicine, Madurai Medical College, Madurai.
3. Dr. R. Ramalingeswara : Professor of Preventive & Social Medicine, Kilpauk Medical College, Madras.
4. Other WHO Workshop participants.

The curricula of the four Medical Colleges, *i e.*, Kilpauk, Madurai, Vellore and Simla were discussed.

The need for the teaching of health education to medical under-graduates was discussed with emphasis on how it should be incorporated in the medical curriculum right from the pre-clinical period.

Medical Curriculum :

It was emphasised that :

(a) theory and concepts of health education can best be incorporated in the pre-clinical and early para-clinical period.

(b) Communication methods and media be taught in the early para-clinical period.
(c) Teaching of health education is to be incorporated into all clinical specialities and not remain isolated in Preventive and Social Medicine.

The roles of the medical practitioner in relation to health education were defined as follows :

1. A doctor as a health educator in his day-to-day pratice, as a family physician, in his hospital practice and in the community.
2. A doctor as a team leader; to identify the roles of the professional health educator and of the other health personnel in health education and to utilise their services effectively for health education programme in the delivery of health care.

The following objectives were framed for the curriculum in health education for undergraduate medical students.

General Objectives

The student is able to understand the importance, principles and methods of health education and apply these in health care to bring about change in health behaviour at the individual, family and community levels.

Specific Objectives

The student is able :

1. To understand the role of the behavioural sciences in relation to the dynamics of health behaviour of the individual, the family and the community.
2. To identify the role of the physician as a health educator in the delivery of health care.
3. To identify the role of the professional health educator and of other health personnel in health education and to utitise their services effectively for health education in delivery of health care.

A. Course content to be covered by the Department of Preventive and Social Medicine

I. Behavioural Sciences :	*Hrs.*
1. Role of behavioural sciences in health education.	1
2. Behaviour in relation to health.	1
3. Social factors influencing health behaviour of individual family and community.	1
4. Beliefs, values, norms, practices and habits.	1
5. Community, social structure and social power	1
6. Factors influencing social change—promoting factors barriers.	1
7. Decision making process at individual, family and community level.	1
8. Perception, attitudes, process of socialization and learning, theories of earning.	2
9. Social change process—motivation, needs, drives.	1

10.	Communication process & principles.	1
11.	Rapport building and counselling : interviewing techniques.	1
12.	Art of public speaking.	1
13.	Methods and media for individual and group discussion and demonstration.	2
14.	Health Education—philosophy, concepts and principles. Values of health education versus legislation and propaganda.	1
15.	Importance of evalution and follow up for feed back in educational programmes for health care services.	1
		17 *Hrs.*

II. Health Education :

		Hrs.
1.	Health education in medical practice—aims of health education.	1
2.	Physicians's role as a health educator in his day-to-day practice (in hospital, community & private practice).	1
3.	Role of other health personnel in health education (a) job descriptions, (b) opportunities of health education in their functions.	1
4.	Functions of professional health educator in the health team. (a) Planning a health education programme, (b) Preparing other workers for health education, (c) Training, (d) Co-ordination and supervision and (e) Evaluation	1
		4 *Hrs.*

B. Involvement of other faculty in the teaching of health education

Other clinical faculties should highlight the components and opportunities of health education in the teaching of their respective subjects.

FIELD PRACTICE

Pre-internship period

1. Behavioural Science Field Practice (See Annexure—I).
2. To identify, plan and implement the health education programme as a part of the total health care services.
3. Alternatively a portion of the community can be allotted to a group of students to identify, plan and implement a health education programme as a part of the total health care services.
4. All faculty of the clinical departments should demonstrate the practice of health education in the bedside teaching and in special clinics like

ante-natal, well-baby, diabetic and V.D. Clinics and in other out-patient and in-patient situations.

Internship Period

5. Provide adequate opportunity for

   (a) Practising health education through community organisation.

   (b) Working with the professional health educator and other health personnel for effective health education in the delivery of health care services.

   (c) Addressing small groups of people on health topics, using simple language.

Such opportunities are available in Maternal Child Health and Family Planning Clinics, National Health Programms and in other endemic and epidemic community health problemes.

Teaching Methods

(1) Lectures	(4) Problem Solving Approach	(7) Family Care Programme
(2) Seminars	(5) Role Play	(8) Demonstration
(3) Case Studies	(6) Individual Project.	(9) Small Group Discussions.

Attitude

Appreciation of the importance of health education for efficient delivery of health care serVices.

Skills in

(a) Person to person communication.

(b) Communicating technical knowledge in simple language to groups. Utilising the services of the professional health educator and other health personnel for health education in the delivery of health care.

Evaluation

(a) Question answer method preferably by multiple choice questions.

(b) Progress evaluation of the student by using 5 point scale.

SUMMER WORKSHOP ON HEALTH EDUCATION IN DELHI HOSPITALS

(July 4 — 7, 1979)

REPORT OF COMMITTEE

Subject : "To review and suggest modifications in the health education component of the existing curriculum for undergraduate medical students".

Resource Person : Dr A.K. Chakravorty
Central Health Education Bureau

1. Introduction

In view of the increased emphasis on the preventive and promotional aspects of health care, and the changed concept of health from the mere absence of disease to that of complete physical, mental, social and even spiritual well-being, the orientation of a medical graduate to the changed concept has become increasingly important.

All medical and other health personnel have a moral obligation to the community to teach and practise the prevention of illness and reduce the load of sickness and disease from the community. Group C consisting of eleven members from various hospitals and other health institutions in Delhi/New Delhi was assigned the task of reviewing the existing curriculum for undergraduate medical students and suggesting modifications. Dr T.R. Anand, Professor of Hospital Administration, National Institute of Health Administration and Family Welfare was elected Chairman and Dr I.H. Khemani, Deputy Medical Superintendent, Lady Hardinge Medical College and Hospital the rapporteur. The group unanimously agreed about the felt need of such an exercise.

2. Present Situation

2.1 Present curriculum for undergraduata students from first professional to final professional and internship period was studied. Exact situation as existing at present in All-India Institute of Medical Sciences, Maulana

Azad Medical College and Lady Hardinge Medical College was described by representatives from these institutions respectively. Picture was more or less similar and is described below :

2.2 The basis for imparting health education teaching to the medical undergraduates is formed by instruction in the basic principles of the behavioural sciences which is done during the pre-clinical period. Behavioural sciences are taught in the form of 10-12 hours of didactic teaching followed by about 2 hours of case reviews in the hospital. This is included with about 4 hours of discussion on the cases.

2.3 Teaching of health education programme is done as follows :

- 2-4 hours of didactic teaching in the IVth or final year. (This included definition, objectives, scope and need, methods etc.)

- The use of health education in the prevention and control of communicable and non-communicable diseases and in national health programmes is emphasised when these are discussed.

- Particular emphasis is laid on the use of health education in relation to family planning and MCH.

- Practical experiences are provided during the family health advisory service programme in the final year and in field practice areas during the period of internship. This is done by both demonstrations and practice in the health centres, school and community in the field practice areas.

3. Need for Strengthening Training in Health Education

The Group unanimously agreed that in the present set-up of training in health education for the undergraduate medical students, a touch of knowledge is provided through the preventive and social medicine department. This is not sufficient to provide the right basis for our future doctors, when they come face to face with the problems of comprehensive community health care. Hence the expansion of the rudimentary knowledge of health education in addition to its practical application is needed in the present day context of health services. During their undergraduate course they are to be sensitive and alert to the educational opportunities and possibilities in the patient-doctor relationship and to become conscious of their educational influence on community.

4. Areas

The Group felt that in addition to being a clinician and health worker a young medical graduate in the community has to play multiple roles, that of leadership, supervisor and administrator for health personnel, a friend, philosopher and a guide to individual and family. The training of medical student must include those aspects of health education which are complementary to the technical interventions relating to diseases, its prevention and treatment and improving health, areas

which can help the undergraduate medical student in understanding the patient and community in a better way. Group felt that there is no controversy about different roles between a medical graduate doctor and a health educator. The latter is to provide technical aid for health education work. There can therefore be no duplication of curricula. Medical graduate is to be imparted skills or knowledge according to the expected role he is to play in the community. Broad areas are :

4.1 *Establishing rapport with the patient, family and community* is an important skill which should be possessed by the students, to discharge their functions efficiently in O.P.D. and wards and community.

4.2 *Art of Interviewing* : Students to learn how to elicit information from the patient in a family.

4.3 *Psycho-social history taking* will help the students to understand the patients in his total environment. This is essential to understand multiple etiology of disease and health and will help him giving total health care.

4.4 *Imparting technical information* on health matters in simple language while discharging their duties in any situation.

4.5 *Public speaking* : Students to learn how to address a small group and large group regarding health topics.

4.6 *Use of audio-visual aids* : Students to learn how to select and use proper situation for getting desired effect.

4.7 *Conduct meetings & report writing* : Students to learn through the demonstration how to arrange, conduct and write reports on the meetings regarding clinics, wards or community health education opportunities.

4.8 *Organizing training programmes* : Students may be involved in all aspects of training programmes organized for the health staff of hospital or primary health centre regarding health education aspects.

4.9 *Motivation* : Students may be taught through demonstration by the health education experts, how to motivate an individual group or community for accepting the message concerning health.

4.10 *Communications* : Students must learn the process of communications so that they can communicate the health message effectively to the receivers.

4.11 *Leadership* : To be a successful community worker, students must know how to identify community leaders and how to work with them to make health programmes more successful.

4.12 *Exploring resources* : Students must learn how to explore resources to start any health programme in the community or in a hospital settings, the resources may be internal or external, this they can learn by means of demonstration.

4.13 *Education* : Students should be in a position to identify the felt needs of health education in a special clinic, O.P.D., wards, community (urban & rural).

4.14 *Team approach* : Public health work is becoming more and more a team work of which medical doctor is the leader. He/she is to be trained in this team approach.

4.15 *Programme development* : Planning a programme and evaluating at local level according to the local needs involving local people and exploiting local resources is the basis of community organisation.

5. Type of Training

There should be less emphasis on didactic lectures. Major portion of time of the student shall be devoted to demonstrations, group discussions, seminars, joint case presentations and inter-departmental teaching, field postings and family care programmes to enable them to work effectively in community. They must know the difference between instructions and health education and propaganda and health education. They must know health education means translation of what is known about health into desirable individual and community behaviour patterns by means of educational process.

6. Role of Social and Preventive Medicine Department

The fact that the department of P.S.M. would play the pivotal role in the training of medical undergraduates in health education was generally accepted.

Apart from providing the basic didactic teaching and imparting the practical training in the basic concepts of health education (its objectives, scope, need, methods and their use etc.) the P.S.M. department should co-operate in the health educational activities of the various clinical specialities. A close working relationship should be forged between department of P.S.M. and clinical specialities so as to incorporate health educational activities in the practice of medicine. Health education would thus not be treated as a separate or isolated entity.

The field practice areas (both urban and rural) attached to the department of P.S.M. provide an unique opportunity for the demonstration of health education in wide range of activities of undergraduates training and for practical experiences during the period of intership

Health education (demonstration and practice) should be one of the major components of the family health advisory service during the final year period.

Health Education Unit in each department of P.S.M. headed by a person of rank of Asstt. Prof./Reader, Health Education.

7. Role of Other Departments

Important clinical departments to take parts in training in health education and other preventive and promotional work are :

1. Obstetrics and Gynaecology
2. Paediatrics
3. Medical
4. Eye
5. Dental
6. Skin and S.T.D.
7. E.N.T.
8. Physical medicine and rehabilitation
9. Dietary
10. Others

This is to be achieved by demonstrations, discussions, presentation of cases in out-patient department clinics, wards. While discussing a disease the diagnosis, management prevention, health education must also be discussed in theory as well as practical.

Joint case presentation by different departments with emphasis on applied aspect will encourage integration approach and comprehensive health care.

8. Programming of Training

8.1 Skill or knowledge to be learned is already dealt with in detail on pages 88-89 paragraph 4.1 to 4.15 methodology is also discussed, while discussing type of training to be imparted. Role of social and preventive medicine department as well as major clinical departments in imparting training in health education have also been discussed. Brief programming/or imparting various skills and knowledge is given below :

8.2 *During preclinical period* : Theory and practice is to be given about interview art, psycho-social history taking, public speaking, communication in a scientific manner.

8.3 *During Clinical period* in continuation about continued study of use of audio-visual aids, rapport with patients family and community, imparting technical information in simple language, art of motivation, recognising leaders in community; identifying health education needs and opportunities are to be added. The students must be encouraged to learn these skills by doing.

8.4 *During internship period* : Application of all knowledge gained and skills learnt will continue. They should further be encouraged to organise and conduct meetings, report writing, organize training programmes, explore resources internal as well as external and learn art and need of team work. They should also learn about programme development and evaluation at local level.

Recommendations

9.1 The Group unanimously recommends the strengthening of training in health education at undergraduate level for medical students to prepare

them fully to practise and provide comprehensive health service to community.

9.2 The Group felt that part of training should not be left to Social and Preventive Medicine Department alone. The Social and Preventive Medicine Department (or Department of Community medicine) is to play a pivotal role; but all major clinical departments must integrate teaching of health education and prevention as a part of their teaching while discussing about any disease or syndrome.

9.3 Training should be imparted in such a manner that medical graduates should learn to develop right attitudes, become sensitive and alert to the education opportunities and possibilities while treating the sick.

9.4 The training of medical students must include those aspects of health education which are complementary to the technical instructions relating to diseases, its prevention and treatment and improving health status, areas which can help the student in understanding patient and community in a better way.

9.5 There should be less emphasis on didactic lecture and more emphasis on practical training through demonstration, group discussions, seminars, single or joint case presentations in O.P.D., clinic, wards, field or family care programmes. They should be actually involved in 'doing' themselves with available guidance so that they become self-confident, develop personality and individuality and fulfil their role in community as teachers, supervisors and administrators for health team.

9.6 A detailed list is given of what skills and knowledge should be provided in relation to health education to an undergraduate medical student throughout his training period; starting from pre-clinical to clinical, continued to internship programme and ultimately in practice. Basic skills and knowledge are provided during the student years Students must develop attitude of self education.

9.7 The Group felt that during internship period in addition to practice in health education they must be encouraged to learn conducting meetings, report writing, organising training programmes, exploring resources internal as well as external and learn the art and need of team work.

Analysis of Replies on Present Status of Health Education Received by CHEB from Medical Colleges
(up to 27 September 1978)

- Curriculum of preventive and social medicine indicating total number of hours spent on teaching of health education at undergraduate level.
- Number and designation and qualification of faculty engaged in teaching of topics covered under the total curriculum for health education.
- Any other discipline in which health education is taught.
- Nature of practical experience provided to student in developing skills in health education.
- Detailed information regarding teaching of health education and post-graduate courses conducted at your institute.

Name of College	State	Teaching of Health Education		Curriculum of PSM	Other subjects in which H.E. is taught	Teaching of H.E. at P.G. level	Lecturers in H.E. in position.	Remarks
		Theory	Practical					
1	2	3	4	5	6	7	8	9
1. Jawaharlal Nehru Medical College, Belgaum	Maharashtra	No information	No information	Sent in detailed curriculum	In Obst. & Gynae & F.P.	Nil	One Lecturer in Soc. Science	H.E. is included in the total curriculum & PSM
2. Andhra Medical College, Visakhapatnam	A.P.	12 hours teaching	72 hours	Not sent	H.E. is taught as an integral part of clinical subjects.	Not so far. P.G. course in RSM just started.	One Lecturer in H.E.	Students (IV yr.) are taken for field visits and 3 hrs. a day for 1 month for H.E., in Nutrition, Environmental Sanitation, Vital Statistics, etc.
3. M.L.B. Medical College, Jhansi	U.P.	10 hours teaching	8 hrs. practical	Not sent	Nil	No information sent	Lecturer in H.E. with DHE	Students given practice at village level in H.E.

1	2	3	4	5	6	7	8	9
4. Topiwala National Medical College, Bombay	Maha-rashtra	8 hrs. as recom-mended by MCI	Students in-volved in H.E. schools & urban slums	Not sent	Not known	4 hrs.	-	Schools and slums talks notes, students interested.
5. Medical College, Amritsar	Punjab	18 hrs.	Family & community	Not sent	Does not know	Some practical	Nil	Talks AV aids at UG Interns give group talks.
6. Medical College,	Mysore	6 hrs.	Not stated. 20 hrs. field work in-cludes health education.	Not sent	Nil	Nil	District health educator as guest. No H.E. lecturer on staff	-
7. The Kasturba Medical College, Manipal	Mysore	Nil specific H.E.	Nil specific	sent	Paed. O & G	Mention-ed among other activities	Health Educa-tor Incl. : in other subjects.	Taught in terms III, IV, H.E. may be integrated.
8. Assam Medical College, brugarh	Assam	5 hrs.	Taught with other subjects	Not sent	Some clinical disciplines	-	H.E. & B.Sc.	Students inter-ested. Want to plan UG course.
9. RNT Medical College, Udaipur	Rajas-than	12 hrs.	Included in field work.	Not sent	Family Care. School Health	Yes	I MA Soc. & DPH	-
10. Armed Forces Medical College, Pune - I	Maha-rashtra	4 hrs.	Slum & rural area, Wards medico-social & clinical	Not sent	Medicine Paediatrics O & G	20 hrs.	I MA Soc. Cert. CHEB I MS worker I PH Nurse 2 case workers	Postgraduate course sophisti-cated

1	2	3	4	5	6	7	8	9
11. B.J. Medical College, Ahmedabad	Gujarat	Vague 2	15 hrs.	Not sent	Nil	30 hrs.	Nil	Haphazard
12. Karnataka Medical College-Hubli	Mysore	40 hrs. for theory and practice		Sent	Nil	Nil	E	Specific mention of Hospital Health Education Doctors' role
13. M. Gandhi Instt. of Med. Services, Sevagram, Wardha	Maharashtra	100 hrs. for theory and practice		Sent	Paed. O & G Med.	Included in community medicine	Health Educator full-time	Family study GOPD Social service camp
14. VSS Medical College, Burla, Sambalpur	Orissa	6 hrs. 4th year	Incl. in 200 hrs. field work	Sent	Nil	Included	Nil	
15. Govt. Medical College, Surat	Maharashtra	5 hrs.	7 hrs.	Not sent	Paed. & Obst.	Same as undergraduate	Nil	H.E. applied to Nutrition Communicable diseases, Environmental Sanitation etc.
16. Medical College, Nagpur	Maharashtra	H.E. taught in all PSM subjects		Not sent	Paed. & O & G	Not specially	Health Educator trained Sanitary inspector	Saminars 3 out of 20 conern Health Education Journal articles and Research
17. Grant Medical College, Bombay	Maharashtra	4 hrs.	Field Work	Not sent	National Health Programmes OPF	DPH some	Health Educator in Urban Health Centres	Welcomes Workshop on the teaching of H.E., in Medical Education
18. King George Med. College, Lucknow	U.P.	10 hrs.	Integrated	Sent	Paed. G & O	DPH MD incl.	MPH (Calif.) MA	Permeates clinical and PSM + Internship

1	2	3	4	5	6	7	8	9
19. MGM Medical College Jamshedpur	Bihar	3	Little or none	Not sent	Nil	Nil	Nil	
20. AIIMS Ansari Nagar, N. Delhi.	Delhi	1+	? ? Integrated	Sent	Paed.	25 hrs.	I Dip. HE Asstt. Prof. PSM	Family Health Rural and Urban Health Centre posting
21. S.V. Med. College, Tirupati	A.P.	6 hrs.	?	Sent	Clinical & Social	Family Health mentioned	I DHE	Field & hospital experience
22. Stanley Med. College, Madras	Tamil Nadu	10	Combined with field studies	Not sent	Nil	Same as under-graduate	Proposed	
23. MGM Med. College, Indore	M.P.	5	Rural posting during intern-ship	Not sent	Nil	Nil	Nil	
24. Kakatiya Med. College, Warangal	A.P.	Provided for in SPM		Sent	Nil	Nil	MA	
25. Medical College, Ahmedabad	Gujarat	Not taught separa-tely, but integrat-ed in tea-ching of C.D., Env. Sanita-tion, MCH & occupa-tional diseases	Family surveys rural field experience	In brief	Almost Nil	Nil	One with DHE	5% of total time in these lectures are spent in teaching of of health educa-tion thus a total of 44 hours as stated

	1	2	3	4	5	6	7	8	9
26.	G.R. Medical College, Gwalior	M.P.	7 hrs. teaching	15 hrs. practical demonstration	Not sent	MCH& Nutrition	Nil	Nil	Students are allotted one family for 1½ years and they take total health care of these families and maintain family folders.
27.	S.P. Medical College, Bikaner	Rajasthan	9 hrs.	Done quite elaborately	Not sent	-	-	One with DHE known as Lect. in HE & FW	Students learn to plan and evaluate the H.E. programme
28.	S.M.S. Medical College, Jaipur	Rajasthan	7 hrs.	Done in detail	Sent	-	Only in DPH & MD (PSM)	One with DHE	Practical aspects of H.E. sent in detail.
29.	Medical College, Trivandrum	Kerala	4 hrs.	Nil	Sent	Nil	In DPH	-	-
30.	Miraj Medical College, Miraj	Maharashtra	Nil	Nil	-	-	-	Nil	
31.	L.L.R. Medical College, Meerut	U.P.	8 hrs	12 hrs.	Nil		-	One with DHE under P.P. Programme.	
32.	Rangaraya Medical College, Kakinada	A.P.	5 hrs.	Nil	Not sent	Nil	Nil	One with DHE Lect. in HE and F.P.	